PATIENT DEMOGRAPHICS

Account No: FOR OFFICE USE ONLY

Chart No: FOR OFFICE USE ONLY

Sex: M

Last Name:

First Name:

MI:

Address:

Apt/Unit #:

City:

State:

Zip:

SSN:

DOB:

Home Phone: ☐

Age:

Work Phone: ☐

Occupation:

Cell Phone: ☐

E-mail:

Check the phone you prefer as 1st choice

May we communicate with you via E-mail? Yes / No

Emergency Phone:

Contact:

Relationship:

Language:

(If other than English)

Race:

(White , Hispanic, Black, Asian, Native American)

Smoking Status:

(Current, Former, Never, Heavy, Light)

Religion: *(optional)*

(Christianity, Judaisim, Hinduism, Islam, Other)

Referred by:

Performing Provider:

KHAVARIAN, CAMERON

Primary Care Provider (Family Doctor)

Office Location:

Cameron Khavarian, MD, Inc

Facility:

NEWPORT MEN'S HRT

Marital Status:

(Single, Married, Divorced, Widowed, Separated)

Confidential Men's Medical Questionnaire

Date: _____

MEDICAL HISTORY

	Have you personally ever had?			
	No	**Yes**	**Not Sure**	**Comments**
High blood pressure?	❒	❒	❒	_____
Stroke?	❒	❒	❒	_____
Diabetes or Pre-Diabetes	❒	❒	❒	_____
High cholesterol?	❒	❒	❒	_____
Obesity / Overweight?	❒	❒	❒	_____
Heart attack?	❒	❒	❒	_____
Heart arrhythmia?	❒	❒	❒	_____
Heart failure?	❒	❒	❒	_____
Asthma?	❒	❒	❒	_____
Chronic bronchitis?	❒	❒	❒	_____
Emphysema?	❒	❒	❒	_____
Tuberculosis ("TB")?	❒	❒	❒	_____
Stomach ulcer?	❒	❒	❒	_____
Short bowel syndrome?	❒	❒	❒	_____
Colitis?	❒	❒	❒	_____
Hepatitis B or C?	❒	❒	❒	_____
Liver cirrhosis?	❒	❒	❒	_____
Abnormal liver enzymes?	❒	❒	❒	_____
Fatty liver disease?	❒	❒	❒	_____
Gallbladder stones?	❒	❒	❒	_____
Kidney stones?	❒	❒	❒	_____
Kidney failure?	❒	❒	❒	_____
Elevated PSA	❒	❒	❒	_____
Enlarged prostate (BPH)?	❒	❒	❒	_____
Male infertility?	❒	❒	❒	_____
Prostate cancer?	❒	❒	❒	_____
Testicular cancer?	❒	❒	❒	_____
Thyroid cancer?	❒	❒	❒	_____
Colon cancer?	❒	❒	❒	_____
Arthritis?	❒	❒	❒	_____
Autoimmune disease?	❒	❒	❒	_____
AIDS / HIV?	❒	❒	❒	_____
Thyroid nodule(s) or mass	❒	❒	❒	_____
Hyperthyroidism (overactive)?	❒	❒	❒	_____
Hypothyroidism (underactive)?	❒	❒	❒	_____
Concussion or Brain injury?	❒	❒	❒	_____
Repeated Head Injuries?	❒	❒	❒	_____
Radiation Therapy for Cancer?	❒	❒	❒	_____
Depression?	❒	❒	❒	_____

Patient: _____

DOB: _____

Confidential Men's Medical Questionnaire Date: _____

STEROID USE HISTORY

	No	Yes
Have you ever used anabolic steroids for sports or performance enhancement?	❒	❒
Are you a competitive professional or amateur athlete?	❒	❒
Have you ever been charged with illegal possession or distribution of steroids?	❒	❒

SURGICAL HISTORY

List all surgery and operations that you have had (major and minor)

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION LIST (include Vitamins and Supplements)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DRUG AND FOOD ALLERGIES

❒ None

_____
_____

SOCIAL PROFILE & HABITS

TOBACCO USE

My smoking status is:
❒ never smoked
❒ former smoker, but quit
❒ active smoker, I still smoke

How many total years did you smoke for? _____ (5, 10, 15, 20, 25, 30, etc)
How many packs per day did you average? _____ (¼, ½, ¾, 1, 2, etc)

ALCOHOL CONSUMPTION

How many alcoholic drinks do you consume per week? _____ ❒ Beer ❒ Wine ❒ Liquor
How many times per month do you get drunk or "buzzed"? _____ ❒ Never

RECREATIONAL DRUGS

Do you use any recreational drugs? (i.e., marijuana, etc) _____

Confidential Men's Medical Questionnaire Date: _____

OCCUPATION

My occupation is: _____

Have you had occupational or accidental exposure to lead, mercury, or arsenic? ❒No ❒Yes

CAFFEINE INTAKE

How many cups of coffee do you drink per day? _____ cups/day ❒ None

How many cups of black tea do you drink per day? _____ cups/day ❒ None

How many cans of caffeinated cola do you drink per day? _____ cups/day ❒ None

BODY WEIGHT

Your Current weight: _____ lbs.

Your weight when you were 18 yrs old: _____ lbs.

EXERCISE HABITS (please check)

❒ I do not currently exercise at all

❒ I do aerobic exercise ____ times per week for ____ minutes each session.

❒ I do weight training ____ times per week for ____ minutes each session.

❒ I do stretching exercises ____ times per week for ____ minutes each session.

❒ I do other sport(s) _____ times per week for ____ minutes each session.

Comments: _____

❒ I have a personal trainer. Trainer Name: _____

❒ I have a gym membership. Gym name: _____

❒ I have had VO2-max test in past. Result: _____mL/kg/min.

SLEEP HABITS

Average hours of sleep per night? _____ hrs

Do you work night shifts? ❒ No ❒ Yes

FAMILY / GENETIC HISTORY

Mother:	❒deceased	❒living	age: ____	conditions:_____
Father:	❒deceased	❒living	age: ____	conditions:_____
Brother-1	❒deceased	❒living	age: ____	conditions:_____
Brother-2	❒deceased	❒living	age: ____	conditions:_____
Brother-3	❒deceased	❒living	age: ____	conditions:_____
Sister-1	❒deceased	❒living	age: ____	conditions:_____
Sister-2	❒deceased	❒living	age: ____	conditions:_____
Sister-3	❒deceased	❒living	age :____	conditions:_____

Do you have any blood relatives who have had Prostate Cancer?

❒No ❒Yes Who? _____